toms, which, in the case of the elder one, were so severe as to threaten the destruction of one eye.

I prescribed protargol in 10 per cent. solution, increasing to 20 per cent. solution, and frequent washings with warm boric-acid solution, with the result that the œdema of the lids rapidly disappeared and the purulent exudate decreased very noticeably. I instructed the mother to continue the protargol instillations, and did not see the child during the following ten days. When called again I found that there was yet some purulent exudate in both eyes, and that the stump of the cord and the left ear were also suppurating. Otherwise the child seemed in perfect health. A much-desired bacteriological examination could not be made at the time. The suppuration of the ear and stump ceased under appropriate treatment, but the ophthalmia was rebellious. Noticing that not even applications of nitrate of silver in 2 per cent. solution had any effect, I made, at the first opportunity, a bacteriological examination of the conjunctival exudate, and found to my surprise a pure culture of the diplobacillus of Morax and Axenfeld. Knowing the almost specific action of zinc salts on this micro-organism, I prescribed sulphate of zinc in a 2.5 per cent. solution, to be instilled once a day. Under this treatment the ophthalmia, which had resisted all medication, got rapidly well. The right eye was cured in eight days, the left one in twenty. The disease had lasted in all nearly three months.

The history of this case will show, I hope, the importance of making an early bacteriological examination in all cases of ophthalmia neonatorum, and demonstrates also the fact that the diplobacillus described by Morax and Axenfeld as the cause of subacute catarrhal conjunctivitis can produce other forms of infectious ophthalmia.

FORWARD DISLOCATION OF THE HEAD OF THE FIBULA.

By J. F. Rinehart, M.D.,
of Oakland, Cal.

Forward dislocation of the head of the fibula is very rarely met with, and for very simple reasons. First, it is firmly bound in its articulation with the tibia by strong ligaments; and, second, there are no very powerful muscles attached to it anteriorly to either in whole or in part pull it from its place

Hamilton reports four cases observed by Savournin, Jobard, Thompson, and Dr. J. Hawley; while the *American Text-book of Surgery*, edited by Drs. Keen and White, says there have been seven cases of this injury reported.

It seems that while seven cases of forward dislocation have been reported at various times, there have been only five cases reported of backward dislocation of the same joint. This would appear at first thought to be the more common of the two, seeing the biceps femoris is attached to the head of the fibula, and is a very powerful muscle. To my mind, it is extremely improbable that any case of dislocation of the fibula has ever occurred through muscular action alone in persons in whom the ligaments of the knee were in normal condition. If muscular action played a very important part in its production the backward dislocation would be much the more common of the two, while in reality it is not so often reported.

The treatment laid down by Hamilton for cases of forward dislocation is to flex the leg upon the thigh and the foot upon the leg at the same time pressure is made upon the dislocated bone. He says Thompson and Jobard were unable to effect reduction when the leg was extended.

In a case of my own I found the following:

The cause was direct violence, the limb having been caught between two freight cars in such a way that the tibia was pressed backward and the fibula forward. The symptoms were absence of the bone in its proper place and undue prominence in front of where the articulation should have been. The X-ray showed that the bone had been completely torn from its articulation and pulled forward. It was impossible to effect the slightest change in the position of the bones by traction upon the foot either alone or accompanied by pressure upon the head of the fibula. Reduction was accomplished by flexing the leg upon the thigh, the foot upon the leg, both as completely as possible, by making firm pressure upon the dislocated bone and by having extension gradually made while this pressure was increased. The bone slipped into place with considerable noise as soon as extension of the leg was begun.

A NOTE ON OSTEOPHYTES OF THE NASAL CHAMBERS.

By Alexander W. MacCoy, M.D.,
OF PHILADELPHIA.

It is some years since the subject of osteophytes in the nasal chambers first began to interest me. During the progress of an operation for deflection of the nasal septum, while I was making explorations in the nasal chambers, I became aware of certain sharp, rough, coral-like deposits situated within the nasal passages. As they proved to be neither necrotic nor rhinolithic aggregations, nor exostoses, I considered them osteophytes. These osseous bodies found in the nasal chambers have the anatomical arrangement and composition of osteophytes. Their formation being arranged in laminated or radiated structures, such anatomical arrangement determines the fitness of the name.

I have neglected to investigate the literature on this subject, having